Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

FAIRBANKS OCULAR PROSTHETICS INC
329 21ST AVENUE NORTH SUITE 1
NASHVILLE TN 37203

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
ARGONAUT SOUTHWEST INSURANCE CO

Carrier's Austin Representative Box
Box Number 17

MFDR Tracking Number
M4-11-2755-01

MFDR Date Received
APRIL 12, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We dispute the shorted payment of the claim for our patient [injured employee]. As we have stated to the insurance company covering [injured employee] we have been short paid for services rendered and pre-authorized for the claimant. We provided these services outside of the state of Texas, and we are not subject to the laws and pricing schedule that the state of Texas has established. This service was rendered in Tennessee. We expect full payment for our services and are owed the balance f $6817.90. If full payment is not returned to us promptly then our only choice will be to bill Mr. Lozano for the balance."

Amount in Dispute: $6,817.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The DWC-60 from the Requestor lists the dispute as a fee dispute. The fees were originally audited under the Tennessee workers' compensation medical fee reimbursement guidelines for this Texas workers' compensation claim. Respondent is sending the bills for reauditing under the applicable Texas workers' compensation fee guidelines and will supplement this response when the results are obtained."

Response Submitted by: Downs-Stanford, PC, 2001 Bryan ST., Ste. 4000, Dallas, TX 75201

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 21, 2011	HCPCS Code V2627 HCPCS Code V2628	$6.817.90	$360.76

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.

2. 28 Texas Administrative Code §134.203 sets out the guidelines for reimbursement in resolving a medical fee dispute.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   Explanation of benefits were not submitted by either party. The Requestor submitted a copy of check number 009017751, dated February 15, 2011 showing a payment of $1,892.10 was made by ARGO Group US.

Issues

1. Under what authority is a request for medical fee dispute resolution considered?
2. Did the respondent correctly reimburse the requestor in accordance with Medicare fee schedule times 125%?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor provided durable medical equipment (DME) services in the state of Tennessee on January 21, 2011 to an injured employee with an existing Texas Workers' Compensation claim. The requestor was dissatisfied with the respondent's final action. The requestor filed for reconsideration nd was denied additional payment after reconsideration. Then, the requestor filed for dispute resolution under 28 Texas Administrative Code §133.307. The Division concludes that because the requestor sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of additional payment, the dispute is to be decided under the jurisdiction of the Texas Workers' Compensation Act and applicable rules….
2. 28 Texas Administrative Code §134.203(b)(1) states in part that for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits. According to the DMEPS 2011 Fee Schedule HCPCS Code V2627 is valued in Texas at $1,508.74 and HCPCS Code V2628 is valued at $365.54. Per 28 Texas Administrative Code §134.203(d)(1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule. The total value of both codes, including the 125 percent of the fee listed, is $2,342.86, the respondent reimbursed the requestor a total of $1,982.10.
3. Review of the submitted documentation finds that the respondent did not reimburse the requestor in accordance with 28 Texas Administrative Code §134.203(b)(1) and (d)(1).

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $ 360.76.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $360.76 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 6, 2012 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.